Piney Orchard
DENTAL

Dental $avings Plan Application Form

Primary Plan Holder:

Effective Date: _____
FOR OFFICE USE ONLY

First Name: _____ Last Name: _____ Middle Initial: _____ Social Security # _____

Address: _____ City: _____ State: _____ Zip: _____

Contact Phone #: _____ Email: _____ Bithdate: _____

Annual Membership Cost: $499

Additional Family Members to be Covered:

Additional Cost per Member:

Name: _____ Relationship: _____ Birthdate: _____ Add: **$476**

Name: _____ Relationship: _____ Birthdate: _____ Add: **$376**

Name: _____ Relationship: _____ Birthdate: _____ Add: **$365**

Name: _____ Relationship: _____ Birthdate: _____ Add: **$310**

***Total Amount Due:** _____

Payment Method:

☐ Cash (in-office only**)

**If paying with cash, please return this application to our office in person. Do not mail cash payments.

☐ Check (make checks payable to Piney Orchard Dental and enclose check with application)

☐ Credit Card #: _____ Exp. Date: _____ CVC: _____

*Annual fee is required at enrollment and cannot be financed. Membership fees for Dental $avings Plan is NON-REFUNDABLE. Piney Orchard Dental reserves the right to modify, change, or discontinue the Dental $avings Plan, Savings Plan Plus, terms, fees, and services at the company's discretion upon written notice from Piney Orchard Dental prior to your anniversary renewal date.

Please mail this completed application with appropriate payment (check or credit card info) to our dental office location:
Piney Orchard Dental - 8743 Piney Orchard Pkwy, Ste. 111, Odenton, MD 21113

By signing below, I acknowledge that I have read the Dental $avings Plan brochure and understand the plan details, benefits, and limitations.

Member Signature: _____ Date: _____